Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

REQUEST FOR EXCEPTION TO POLICY (ETP) FOR USE OF RESTRICTIVE PROCEDURES

LAST NAME	FIRST	MIDDLE	BIRTHDATE	COMMUNITY PROTECTION PARTICIPANT ☐ Yes ☐ No

ADDRESS	CITY	STATE	ZIP CODE

PROCEDURE(S) FOR WHICH EXCEPTION IS REQUESTED

Does this person have a legal representative? ☐ Yes ☐ No

If yes, provide the following:

LEGAL REPRESENTATIVE/S NAME	TELEPHONE NUMBER (INCLUDE AREA CODE)

AGENCY REQUESTING ETP

AGENCY'S NAME	TELEPHONE NUMBER (INCLUDE AREA CODE)

ADDRESS	CITY	STATE	ZIP CODE

ADMINISTRATOR'S SIGNATURE	DATE	PRINT ADMINISTRATOR'S NAME

DOCUMENTATION

Attach the following documentation per DDD Policy 5.15, Use of Restrictive Procedures:

- ☐ a. Definition of target behavior(s)
- ☐ b. Functional assessment or psychosexual evaluation
- ☐ c. Description of positive behavior support strategies
- ☐ d. Description of restrictive procedure(s)
- ☐ e. Data plan
- ☐ f. Monitoring plan and evaluation plan
- ☐ g. Written consent of the person
- ☐ h. Written consent of legal representative
- ☐ i. Other (specify):

CASE RESOURCE MANAGER REVIEW

RECOMMEND APPROVAL ☐ Yes ☐ No	NAME OF CASE MANAGER	DATE

REGIONAL ADMINISTRATOR'S DECISION

- ☐ ETP approved for _____ months (not to exceed 12 months).
- ☐ Resubmit with modification(s) as specified (or attach additional sheet):
- ☐ ETP not approved.

COMMENTS	SIGNATURE DATE
